Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR MEDICAL CENTER - IRVING
707 HIGHLANDER BLVD
ARLINGTON TX 76015-4319

Respondent Name
WAUSAU BUSINESS INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-11-1696-01

MFDR Date Received
January 26, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Requested 200% of APC, carrier underpaid upon appeal, carrier issued additional $684.78, claim remains underpaid for the amounts indicated."

Amount in Dispute: $2,985.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider billed CPT 23120. This was reviewed and denied as the documentation does not support level of service billed. (X901). April 2004 AAOS Bulletin: Excision of the distal clavicle: This means excision of the entire distal clavicle (approximately 1 cm), not merely shaving off osteophytes at the acromioclavicular joint. The operative did not list the amount of the distal clavicle excised therefore we believe the denial appropriate according to the guidelines set for by the American Academy of Orthopedic Surgeons. . . . Liberty Mutual believes that Baylor Orthopedic & Spine Hospital at Arlington has been appropriately reimbursed for services rendered. . . "

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2010	Outpatient Hospital Services	$2,985.25	$2,223.87

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.

3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 sets out requirements regarding written notification to health care providers of contractual agreements for informal and voluntary networks.
5. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

- X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
- Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
- Z346 – RIGHTS SIDE. (Z346)
- X094 – CHARGES INCLUDED IN THE FACILITY FEE. (X094)
- X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED. (X901)
- B291 – THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUIDELINES; NO SEPARATE PAYMENT ALLOWED. (B291)
- P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
- U849 – THIS MULTIPLE PROCEDURE WAS REDUCED 50%% ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES. (U849)

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Does the submitted documentation support procedure code 23120?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code P303 – "THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)." Review of the submitted information found insufficient evidence to support that the services in dispute are subject to a contracted fee arrangement. Pursuant to 28 Texas Administrative Code §133.307(e)(1), which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available" and Texas Labor Code §413.011(d-3), which states, in pertinent part, that "An insurance carrier shall provide copies of each contract described by Subsection (d-1) to the division on the request of the division. . . . For medical fee disputes that arise regarding non-network and out-of-network care, the division may request that copies of each contract under which fees are being paid be submitted to the division for review," on March 15, 2011, the Division requested the respondent to provide a copy of the referenced network contract and documentation to support provider notification as required under 28 Texas Administrative Code §133.4. The respondent replied that "We have confirmed that this NON HCN claimant's bill was not reduced according to a PPO Network Contract." The respondent did not otherwise submit copies of the requested information. The above denial/reduction reason is not supported. Pursuant to Texas Labor Code §413.011(d-3), which states, in pertinent part, that "the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract: (1) is not provided in a timely manner to the division on the division's request," the disputed services will be reviewed based on the available information for payment in accordance with applicable Division rules and fee guidelines.
2. The insurance carrier denied disputed services billed under procedure code 23120 with reason code X901 – "DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED. (X901)." Procedure code 23120 represents a partial claviculectomy. The insurance carrier contends that "This was reviewed and denied as the documentation does not support level of service billed. (X901). April 2004 AAOS Bulletin: Excision of the distal clavicle: This means excision of the entire distal clavicle (approximately 1 cm), not merely shaving off osteophytes at the acromioclavicular joint. The operative did not list the amount of the distal clavicle excised therefore we believe the denial appropriate according to the guidelines set for by the American Academy of Orthopedic Surgeons." Review of the operative report finds that the provider documented that "The AC joint itself was then removed, and rongeurs were then utilized to remove the distal aspect of the clavicle. . . " Per 28 Texas Administrative Code §134.403(d), for coding, billing, reporting, and reimbursement of covered health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the

date a service. Per Medicare's Program Integrity Manual §3.3 A and B, "The primary authority for all coverage provisions and subsequent policies is the Social Security Act. The MACs, CERT, Recovery Auditors, and ZPICs shall use Medicare policies in the form of regulations, CMS rulings, national coverage determinations (NCDs), coverage provisions in interpretive Medicare manuals, local coverage determinations (LCDs) and MAC policy articles attached to an LCD or listed in the Medicare Coverage Database to apply the provisions of the Act…an item/service is correctly coded when it meets all the coding guidelines listed in the Current Procedural Terminology-4 (CPT) book, ICD-9, HCPCS and CMS policy or guideline requirements, LCDs, or MAC articles." The American Academy of Orthopaedic Surgeons is not listed as an authority with regard to Medicare documentation requirements. No information was found to support that Medicare requires the specific amount of material removed from the clavicle to be reported. Review of the submitted medical records finds that the documentation supports the service as billed. The insurance carrier's denial reason is not supported. The disputed service will therefore be reviewed per applicable Division rules and fee guidelines.

3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 24341 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0051, which, per OPPS Addendum A, has a payment rate of $3,139.68. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,883.81. This amount multiplied by the annual wage index for this facility location of 0.9434 yields an adjusted labor-related amount of $1,777.19. The non-labor related portion is 40% of the APC rate or $1,255.87. The sum of the labor and non-labor related amounts is $3,033.06. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR may be estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2010 Default CCR as 0.2223. This ratio multiplied by the billed charge of $10,312.00 yields a cost of $2,292.36. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $3,033.06 divided by the sum of all APC payments is 53.90%. The sum of all packaged costs is $1,359.86. The allocated portion of packaged costs is $732.94. This amount added to the service cost yields a total cost of $3,025.30. The cost of this service exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers and any multiple procedure discount, is $3,033.06. This amount multiplied by 200% yields a MAR of $6,066.12.

   - Procedure code 23130 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0051, which, per OPPS Addendum A, has a payment rate of $3,139.68. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,883.81. This amount multiplied by the annual wage index for this facility location of 0.9434 yields an adjusted labor-related amount of $1,777.19. The non-labor related portion is 40% of the APC rate or $1,255.87. The sum of the labor and non-labor related amounts is $3,033.06. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including outliers and any multiple procedure discount, is $1,516.53. This amount multiplied by 200% yields a MAR of $3,033.06.

- Procedure code 23120 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0050, which, per OPPS Addendum A, has a payment rate of $2,141.60. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,284.96. This amount multiplied by the annual wage index for this facility location of 0.9434 yields an adjusted labor-related amount of $1,212.23. The non-labor related portion is 40% of the APC rate or $856.64. The sum of the labor and non-labor related amounts is $2,068.87. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including outliers and any multiple procedure discount, is $1,034.44. This amount multiplied by 200% yields a MAR of $2,068.88.
- Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
- Procedure code 85610 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.62. 125% of this amount is $7.02. The recommended payment is $7.02.
- Procedure code 85730 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $8.60. 125% of this amount is $10.75. The recommended payment is $10.75.
- Procedure code 81025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.06. 125% of this amount is $11.33. The recommended payment is $11.33.
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.14. 125% of this amount is $13.93. Reimbursement is the lesser of the MAR or the provider's usual and customary charge of $10.00. The recommended payment is $10.00.
- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.
- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.12. 125% of this amount is $15.15. The recommended payment is $15.15.

- Procedure code 71020 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0260, which, per OPPS Addendum A, has a payment rate of $44.90. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.94. This amount multiplied by the annual wage index for this facility location of 0.9434 yields an adjusted labor-related amount of $25.42. The non-labor related portion is 40% of the APC rate or $17.96. The sum of the labor and non-labor related amounts is $43.38. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $43.38. This amount multiplied by 200% yields a MAR of $86.76.
- Per Medicare policy, procedure code 93005 is unbundled from procedure code 24341 billed on the same date of service. Per Medicare policy, payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.

5. The total recommended payment for the services in dispute is $11,312.82. This amount less the amount previously paid by the insurance carrier of $9,088.95 leaves an amount due to the requestor of $2,223.87.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,223.87.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,223.87, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	September 14, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.